# Atlantic Brain and Spine, P.A.

☐ 2208 S. 17th St., Suite 201, Wilmington, NC 28401 ☐ 2800 Ashton Dr., Suite 200, Wilmington, NC 28412

☐ 215 Station St., Jacksonville, NC 28546 ☐ 512 Village Rd, Suite 207, Shallotte, NC 28470

**Phone:** (910)763-3333 or (910)799-2262 **Fax:** (910)799-2943

Patients can find paperwork and maps on our website at www.atlanticbrainandspine.com

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**Circle Preference:** First Available Dr. Beecher Dr. Brown Dr. Cappuzzo Dr. Huffmon Dr. Stricsek Dr. Thomas ***ASAP***

**REFERRING PHYSICIAN**: _____
NAME NPI# PHONE NUMBER

**PERSON COMPLETING THIS FORM**: _____
NAME PHONE NUMBER

***ASAP – Patient *MUST* have all radiation images on CD or film, to bring to their appointment, and show an urgent problem. Telephone contact is also recommended after referral sheet is faxed for ASAP patient.**

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**PATIENT INFORMATION:**

_____
LAST NAME FIRST NAME MIDDLE/MAIDEN SEX

_____
ADDRESS: STREET P.O. BOX CITY STATE ZIP

(_____) _____-_____ _____-_____-_____
HOME PHONE NUMBER DATE OF BIRTH AGE SOCIAL SECURITY NUMBER

(_____) _____-_____ (_____) _____-_____
CELL PHONE NUMBER EMPLOYER WORK PHONE NUMBER

Is this a second opinion? _____ Previous physician: _____

Reason for referral: _____ Date of injury: _____

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**AN APPOINTMENT CANNOT BE MADE UNTIL THE FOLLOWING INFORMATION IS RECEIVIED.**

- ☐ **INSURANCE CARD(S)**
  - **FRONT & BACK**
- ☐ **OFFICE NOTES**
- ☐ **RADIOLOGY REPORTS**
  - **MRI , CT, MYLEOGRAMS**

(Have the following treatments been performed in the past year?)

- ☐ **RADIOLOGY TESTS**
- ☐ **INJECTIONS**
- ☐ **CHIROPRACTIC TREATMENT**
- ☐ **PHYSICAL THERAPY**

Please Note: *Your office must obtain authorization for **Workman's Comp, Veterans Admin/Optum, Tricare Prime,** and **Vocational Rehab** before the appointment is scheduled. Authorizations should be put under the practice name whenever possible, not the specific physician. **Our tax ID is 20-0062134.** We are unable to get authorization on new patient referrals; they must be obtained by the referring physician's office. Please call us if you have any questions, as we want to make this process as easy as possible.*

INSURANCE AUTH REQUIRED? YES NO AUTH #: _____

CONTACT NAME:_____ CONTACT #: _____

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*Our office makes every attempt to contact the patient within 48 hours to schedule an appointment. Our office will fax a confirmation of that appointment for your records. Thank you for your referral.*